PERFORATING ULCER OF THE FOOT, AND ITS CONNECTION WITH DISEASE OF THE NERVOUS SYSTEM.—Dr. Southam (Manchester) divides cases of perforating ulcer of the foot into three classes: 1. *When the ulcer is entirely due to local causes—for example, suppuration of a bursa beneath a corn.* 2. *When the ulcer occurs in connection with locomotor ataxia, and apparently independent of any disease of the peripheral nerves.* It may occur as an early or premonitory symptom, or as a late or terminal symptom. The relation which perforating ulcer bears to locomotor ataxia is somewhat obscure, for in this affection the morbid changes are usually limited to the spinal cord and posterior nerve-roots, the latter structure only becoming implicated in the latter stages of the disease. Recent investigations, however, show that in certain cases atrophy and sclerosis of the nerve fibres of the sciatic nerve are present, while in others a diseased condition of the terminations of the sensory nerves has been observed. It is quite possible, therefore, research will reveal the fact that in cases of locomotor ataxia complicated by perforating ulcer, disease of the peripheral nerves is also present; otherwise, we must regard the local affection simply as an example of a tropho-neurosis dependent upon changes in the nervous centres. 3. *When the ulcer occurs in connection with diseases of the peripheral nerves, without any evidence of locomotor ataxia or other disease of the central nervous system.* In a case cited, an examination by Mr. Priestley of the nerves of both feet, after amputation, exhibited marked evidence of sclerosis. From identical cases discovered by other writers, it appears that the ulcer may be dependent in some cases on atrophy or disease of the peripheral nerves without any apparent implication of the nerve centres. Of course it is quite possible, he says, that in cases of this kind symptoms of central disease may eventually develop themselves, yet in the case reported six years have elapsed, and as yet no indications of the onset of that condition are present.—*Brit. Med. Journ.*, No. 1173.

AN AFFECTION OF THE SPINAL CORD CONSECUTIVE TO A CONTUSION OF THE SCIATIC NERVE.—Prof. Charcot gives the following case: A well-built man, forty years of age, was stricken down by the blow received from a heavy joist upon the left buttock. Notwithstanding the violence of the blow, no trace of ecchymosis was observed on the part, but after the injury the patient constantly suffered from a permanent pain along the course of the sciatic nerve; four painful spots being present,—the superior femoral, the peroneal, the external malleolar, and that on the dorsum of the foot,—besides intermittent pains, shooting, fulgurating, and accompanied by clonic spasms, with flexion of the leg on the thigh. During the earlier weeks the patient showed a certain degree of muscular weakness in the left inferior extremity. Three months after the accident, all pain having disappeared, the weakness increased so as to render standing impossible. At the end of six months walking was possible for half an hour. At the time when the muscular weakness was most marked, a pain was felt in the lumbar region, lasting several days, also anuria. Catheterization showed that there existed no obstacle to the flow of urine, and still, from that time, the patient had to use a catheter to empty his bladder regularly; at the same period there supervened a partial incontinence of the fæcal matter, and the erections disappeared.

It is evident that there existed a spinal-cord lesion consecutive to the traumatism of the sciatic nerve.

The methodical exploration of the inferior extremities disclosed a notable atrophy of the left side, with tumefaction of the foot, coldness and cyanosis of the periphery, obliteration of sensibility. The muscles, receiving their innervation from the lumbar plexus, preserved their normal energy; on the contrary, those innervated by the great and small sciatic nerves, are decidedly affected at the buttocks, at the thigh, and also at the leg. The gluteus maximus and the gluteus minimus, although innervated by the superior gluteal nerve, were also affected. An attentive examination showed that, on the right side as well, the glutei and most of the other muscles were paretic or atrophied. A study of the electrical reactions of the nerves and muscles showed that the crural nerve was normal; no response followed faradic or galvanic excitation of the gluteus medius; the gluteus maximus on both sides being also inexcitable. The gemeli of the flexors of the thigh presented the degeneration reaction, more marked on the left than on the right side. All these facts tend to confirm the opinion that the lesion of the cord was consecutive to the traumatism of the nerve. This forms a type of lesions known as ascending lesions.—*Progrès médical*, 3–10, May, 1883.

ACUTE ASCENDING PARALYSIS.—Dr. Roussel (*Gaz. d. hôp.*, No. 76) has drawn the following conclusions, based on facts of experimental physiology, and the symptomatology, etiology, and anatomical alterations, furnished by several patients who had exhibited during life a complete clinical picture of Landry's disease. Acute ascending paralysis is not a distinct morbid entity. It is the pathological manifestation of an acute central myelitis, characterized by its invading tendency and the rapidity of its processes. If it happens that the microscopical examination of the nerve centres have, in certain cases, given only negative results, they must be imputed to the rapid evolution of the disease, and the rapid extension of the inflammatory processes to the superior regions of the spinal cord, whose integrity is indispensable to the maintenance of life. Every acute dorso-lumbar central myelitis, with medullary alteration, by assuming an invading process at the beginning, may develop a special form which might be confounded in its clinical evolution with acute ascending paraly-